Texas Department of Public Safety
Regulatory Services Division
www.dps.texas.gov

- *MUST USE MOST **CURRENT** FORM*
- ***TYPED** PREFERRED OR **PRINT** CLEARLY*
- *MAKE SURE ENTIRE CIRCLE IS **FILLED***

CONTROLLED SUBSTANCES REGISTRATION

Modification of Registration Physician Assistant/Advance Practice Nurse

APPLICANT INFORMATION				
Last Name:	First Name:	Middle Initial:	Suffix: (*IF ANY*)	○PA ○APN
Date of Birth:		Social Security Number:		
Email Address:				
CSR Number:			Expiration Date:	
Current Board License Number:			Expiration Date:	
Current Federal (DEA) Registration Number:			Expiration Date:	
Current National Provider Identifier (NPI) (*IF Any*):				
Business Address: (Physical Address required, if using a P.O. Box)				
City:	State:	ZIP + 4:	County:	
Phone Number Type: ○ Office ○ Cell ○ Home	Number:	ext.	International Phone #:	○ Yes ○ No
Applicant: _____ *(Signature)*	Date: _____	, _____ *(Printed Name)*		

Supervising Physician(s) Delegating Prescriptive Authority

Please indicate if you are adding or removing Physician(s). Each Physician must select the drug schedule(s) to be delegated by physician.

SUPERVISING PHYSICIAN INFORMATION ○**Add** ○**Remove**		**Note:** Physician must be registered with TMB for prescriptive authority.	
Last Name:	First Name:	Middle Initial:	Suffix: (*IF Any*)
Medical Board Number:		Expiration Date:	
CSR Number:		Expiration Date:	
DRUG SCHEDULES *(Select all that apply)*			
○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	
"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."			
Supervising Physician: _____ *(Signature)*	Date: _____	, _____ *(Printed Name)*	

**Please use additional pages for additional Supervising Physicians (complete only if necessary)*

PA / APN Last, First & Middle Name:	CSR Number: Expiration Date:

SUPERVISING PHYSICIAN INFORMATION ○**Add** ○**Remove**			**Note:** Physician must be registered with TMB for prescriptive authority.
Last Name:	First Name:	Middle Initial:	Suffix: (*IF Any*)
Medical Board Number:		Expiration Date:	
CSR Number:		Expiration Date:	
DRUG SCHEDULES *(Select all that apply)*			
○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	

"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ____________, ______________________

(Signature) *(Printed Name)*

SUPERVISING PHYSICIAN INFORMATION ○**Add** ○**Remove**			**Note:** Physician must be registered with TMB for prescriptive authority.
Last Name:	First Name:	Middle Initial:	Suffix: (*IF Any*)
Medical Board Number:		Expiration Date:	
CSR Number:		Expiration Date:	
DRUG SCHEDULES *(Select all that apply)*			
○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	

"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ____________, ______________________

(Signature) *(Printed Name)*

SUPERVISING PHYSICIAN INFORMATION ○**Add** ○**Remove**			**Note:** Physician must be registered with TMB for prescriptive authority.
Last Name:	First Name:	Middle Initial:	Suffix: (*IF Any*)
Medical Board Number:		Expiration Date:	
CSR Number:		Expiration Date:	
DRUG SCHEDULES *(Select all that apply)*			
○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	

"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ____________, ______________________

(Signature) *(Printed Name)*

PA / APN Last, First & Middle Name:	CSR Number: Expiration Date:

SUPERVISING PHYSICIAN INFORMATION ○**Add** ○**Remove**			**Note:** Physician must be registered with TMB for prescriptive authority.
Last Name:	First Name:	Middle Initial:	Suffix: (*IF Any*)
Medical Board Number:			Expiration Date:
CSR Number:			Expiration Date:
DRUG SCHEDULES *(Select all that apply)*			
○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	

"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ______________ , ______________________

(Signature) *(Printed Name)*

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"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ______________ , ______________________

(Signature) *(Printed Name)*

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○ (2) SCHEDULE II, NARCOTIC ○ (2N) SCHEDULE II, NON-NARCOTIC	○ (3) SCHEDULE III, NARCOTIC ○ (3N) SCHEDULE III, NON-NARCOTIC	○ (4) SCHEDULE IV ○ (5) SCHEDULE V	

"I am delegating prescriptive authority of the selected schedules to the Mid-Level Practitioner named above."

Supervising Physician: ______________________ Date: ______________ , ______________________

(Signature) *(Printed Name)*